THE CANCER LETTER

P.O. Box 2370 Reston, Virginia 22090 Telephone 703-620-4646

Vol. 7 No. 6

Feb. 6, 1981

Subscription $125.00 per year

DRCCA BOARD OKAYS COOPERATIVE GROUP CONTRACT EXTENSIONS, NUTRITION RESEARCH TRAINING GRANTS

The Board of Scientific Counselors of NCI's Div. of Resources, Centers & Community Activities last week approved one year extensions of three contracts in the Cancer Control Cooperative Group Program; approved a new program to support four to five research training grants in nutrition; and turned down a proposal for nutrition supple-

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In Brief

OLIVERIO MOVES TO DEA; KUSHNER BLASTS NIH SLOW PAY; DEVITA WELCOMES HAWKINS' PROBE

VINCENT OLIVERIO, who has headed NCI's Developmental Therapeutics Program the last four years, has moved from the Div. of Cancer Treatment to the Div. of Extramural Activities. He's helping set up the mechanism for the division's expanded role in reviewing all NCI contracts. **JOHN DRISCOLL**, chief of the Drug Design & Chemistry Section in the Laboratory of Medicinal Chemistry & Biology, is acting director of Developmental Therapeutics. . . . **NIH'S CHRONIC** slow payment of its bills has resulted in delays of delivery of supplies and services to the Clinical Center, National Cancer Advisory Board member Rose Kushner charged at this week's NCAB meeting. "That's a chronic problem we're always working on," Director Vincent DeVita said. "It's a paperwork problem," commented Executive Officer Philip Amoruso. Kushner asked the Board for a resolution demanding improvement, but member Harold Amos said, "We better spend our time on something we can do something about." No action was taken. . . . **PAULA HAWKINS**, new Republican senator from Florida, is chairman of the new Oversight Subcommittee of the Labor & Human Resources Committee. She announced she will investigate NCI and criticized the Cancer Program in a *Newsweek* quote. "I will welcome an investigation," DeVita said. "We're criticized for not meeting expectations of some people and I'm weary of that interpretation of our mandate. I'm proud of the Cancer Program and welcome the opportunity to defend it.". . . **13TH INTERNATIONAL** Cancer Congress, Sept. 8-15, 1982, in Seattle, is ready with its advance program announcement. Write to Dr. Edwin Mirand, Secretary-General, Fred Hutchinson Cancer Research Center, 1124 Columbia St., Seattle, Wash. 98104. There will be nine general symposia in each of the three major areas—preclinical, clinical, and allied sciences. . . . **DEADLINE FOR** applications to enroll in the clinical cytopathology for pathologists postgraduate course March 22-April 3 at Johns Hopkins (***The Cancer Letter*** meetings, Jan. 30) is Feb. 23. Write to Johns Hopkins Hospital, 605 Pathology Bldg., Baltimore, 21205.

DRCCA BOARD TURNS DOWN NUTRITION SUPPLEMENTS IN CLINICAL EDUCATION

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ments to existing clinical cancer education grants.

The Board's actions constituted "concept approval" of the staff proposals. Since the Board still has not been formally constituted, no formal votes could be taken. However, Chairman Stephen Carter in each instance summarized in a "sense of the Board" statement the position he said was the direction he felt the Board wanted to go, and there were no objections. Board members were asked to mail their recommendations to DRCCA Acting Director William Terry.

The three Cooperative Group contracts are those with the Radiation Therapy Oncology Group, Children's Cancer Study Group, and National Surgical Adjuvant Breast & Bowel Project. Approximate funding will be $770,000 for RTOG,.$750,000 for CCSG, and $610,000 for NSABP. The actual dollar amounts will be determined through the usual negotiating process.

The extensions will permit evaluation and testing of the programs and will bring them to (more or less) common expiration dates with the other three Cooperative Groups in the program—Eastern Cooperative Oncology Group, Southwest Oncology Group, and Northern California Oncology Group.

The Board's approval of the extension does not constitute concept approval of the entire program, Terry pointed out. The Board will consider that concept next year.

"There is no question this program has been successful from the Groups' point of view," Terry said. "From the cancer control point of view, that is more debatable."

The program was initiated in 1976 to facilitate transfer of new therapy into community hospitals by affiliating community physicians with Cooperative Groups.

"For the purposes of cancer control," DRCCA said in a statement describing the program, "the key elements of the Cooperative Groups were neither their research experience nor their conduct of clinical trials, but rather their expertise in cancer patient care and their use of clinical protocols, not only for their potential treatment benefits, but also as a guideline for optimal patient management. . . . Objectives are strengthening and enlarging the affiliated hospital programs of the groups, providing support services for patient care and data collection at community hospitals, instituting quality controls for treatment data at community hospitals, providing continuing education for community physicians and other health professionals and field testing and evaluating effective treatments in the community setting."

ECOG Chairman Paul Carbone and NSABP Chairman Bernard Fisher appeared at the Board meeting to defend the program.

"I confess I was originally against this program," Fisher said. "All of my efforts have been directed at upgrading the quality of patient care." Describing his previous efforts in continuing education, which he said is not effective if it consists of "one shot efforts," Fisher said "the single most effective effort I have encountered is the Cooperative Group Cancer Control Program."

Fisher said that critics of the program agree with those medical schools "which have the inane idea that community physicians don't need to be investigators. Within the context of clinical trials (research and the best patient care) are not in conflict."

Describing the program's educational efforts, Fisher said, "Above all, the physician learns how to follow up. When patients are on protocols, recurrences are detected sooner. I believe we are converting community physicians from purveyors to knowledgeable physicians. We haven't come near giving our community physicians the kinds of things they are capable of taking on.

"This program is an instrument to make a contribution to upgrading the quality of care. I consider it a milestone event," Fisher concluded.

The Cooperative Groups were eager to participate in the program because they have found it increasingly difficult to accrue patients in sufficient numbers to carry out clinical trials, a problem encountered by cancer centers, NCI, and others engaged in clinical research. The problem is the result of the increasing number of trained oncologists in community practice, reducing the number of patients available for trials at larger institutions.

The Cooperative Group Cancer Control Program has had an impact on that problem. DRCCA said that in some instances, 20-30 percent of total patient accrual to group protocols is derived through the cancer control contracts.

Carbone confirmed that the program has helped ECOG significantly with patient accrual, with 40 percent of patients now coming from the group's affiliated hospitals. Total number of patients in ECOG trials has remained at about 3,200 a year despite the decreasing number of members of the group (outside the Cancer Control Program).

Carbone discussed briefly early findings in evaluating the cancer control results and admitted it has not all been positive. Despite the apparent lack of difference in toxicity between cancer control patients and those treated by the rest of the group, and that no differences have been observed in protocol compliance or support services, survival has not been as good with the cancer control patients.

"We have to complete the evaluation and find out if there really is a difference in survival and if so, why," Carbone said. He suggested that the difference

plished by adding two years following administrative review to the normal three year grants. Both houses of Congress had approved five year grants in the separate Kennedy and Waxman bills last year, but when they could not resolve other differences, the legislation died.

• An absolute requirement before submitting new and renewal applications will be the letter of intent. This will permit NCI staff to work with centers personnel in defining the budgetary limits in the applications. The new guidelines will require that applicants have a cancer research base of $750,000 to be eligible to apply for core grants.

• "We're hoping the awards will reflect recommended levels of the peer review system, but we cannot guarantee that." Present budget levels for the Centers Program probably would provide only for a modest increase, perhaps no more than seven percent, for competing renewals. However, "We'll strive to develop a mechanism to take into account the judgment of peer review, on a sliding scale." (Terry was referring to the plan previously discussed and tentatively approved by the Guidelines Working Group which would reward those applications with high priority scores and penalize those with lesser scores.)

• The new guidelines would permit center directors to pay from core grants the salaries of young investigators not previously funded and of older, newly recruited investigators not bringing with them any grant support, probably with a two year limit. Directors could use developmental funds for interim salaries of investigators who lose their peer review support to give them an opportunity "to get back into the system."

• Decisions on chargebacks for shared resources will be up to the directors. "They may choose to impose them or not. Obviously, the more that can be charged off to other grants, the more that will be available from the core grant for other center uses."

Terry concluded, "We hope the effect of the new guidelines will be to focus support on areas that are unique to centers."

Timothy Talbot, Fox Chase Cancer Center, was one of AACI's representatives at the Working Group meetings. He expressed considerable bitterness over the guidelines presented by Terry.

"Bill Terry and his staff have labored hard to produce something equitable," Talbot said. "My present sense of disappointment and concern is based on the following perceptions. At the Chicago meeting (of the Working Group), Bill presented a letter to Chuck Moertel (Working Group chairman). It was a superb letter. We all felt it was a document which provided for the necessary restrictions on rate of growth, with a cap, which would prevent runaway budgets. That letter did it all. The terms were liveable and equitable.

"As the day progressed, it was my perception that there were only two or three people . . . vocal enough to turn it around." The guidelines now being proposed "take away from some and give to others," Talbot said.

Terry in the letter to Moertel proposed an overall limit on renewal applications of a 25 percent increase over the current level and a limit on the overall net increase for staff investigator salary support to 10 percent of the total funds requested.

Talbot did not identify the "two or three people" who rejected Terry's suggestions. Talbot acknowledged that Fox Chase is one of the institutions which exceed the 25 percent limit. "To take the average of 60 institutions and say that's the best average for everybody is irrational in supporting science. An attempt to make a straight even line apply to everyone is destructive."

Terry said it "is not fair to attribute the outcome of the meeting to two individuals. More than that agreed that this is reasonable and those two reflected the broad feeling of those at the meeting. No one wants to intentionally harm any institution. The process proposed here should allow those centers to undergo an evolutionary change. I think the phase down can be done without harming anyone."

"We had to work out a reasonable way to live within a limit," Moertel said. The new proposals "offer stability and flexibility and allow us to operate in our own best way. Staff investigator salary support has been used with extraordinary success by a few but to a limited extent by a majority of centers. Under the current guidelines there are no reins on staff investigator salaries. It could eat the Centers Program alive as more center directors realize the virtue of paying salaries from core grants.

"The program we have developed is in the best interests of the Centers Program over all beyond question and is harmful to none," Moertel continued. "I realize there are differences between centers. The six or eight which depend heavily on staff investigator salary support wouldn't be hurt. Fox Chase would not be preferentially hurt. . . . I hope this group can with unity support these proposals."

"We all realize there has to be some limitation," said John Potter, Georgetown Univ. "How is the issue. Guidelines should be flexible enough to allow centers to meet their needs. Some centers may need more salary support than others."

Michael Brennan, Michigan Cancer Foundation, said he agreed "it is wrong to have rules based on averages."

"We're stuck with arithmetic, like it or not," commented Richard Steckel, UCLA. "It is inequitable to apply a median figure as the maximum. I would encourage the (DRCCA) Board and Chuck Moertel's group to reconsider applying the 25 percent limit across the board."

Hilary Koprowski, Wistar Institute, suggested that an overall limit to budget requests be applied but that no limit be placed on salary support and no other restrictions be placed on the flexibility of center directors to use their funds.

"I so move," said Denman Hammond, Univ. of Southern California.

Robert Hickey, M.D. Anderson, disagreed. After explaining again how the overall limit could not be enforced under the present guidelines without a limit on salary support, he commented, "I thought that you were pleased at the conclusion of the Chicago meeting, Dr. Talbot, and I am astonished that you are not."

Hammond argued that "there are two separate principles or issues in the recommendations. One which must be dealt with is the need for some cap to keep budgets in consonance with the amount of money available. Second is the cap on salaries. The overall cap should take care of that. Needs vary. The core grant is to meet needs centers don't get funded from other sources. It is not rational to require the salaries cap unless you are trying to convince the scientific community that working in centers does not give an investigator a competitive advantage."

Terry, directing his remarks to Talbot, said, "You can't convince me that your scientists are not capable of competing for grants (without the degree of salary support from the center they presently receive). They are first class people. We are talking about an indefinite period for the phase down. Some may be able to do it in three years, others six or seven."

"If we go back to the original draft of the proposed guidelines, there was a great deal of inflexibility built into them," said Stephen Carter, Northern California Cancer Program. "Chuck Moertel's group removed almost all restrictions on flexibility. Why pick on this one aspect? Dr. Hickey put his finger on it. This (staff investigator salaries) is the one part of the core grant not reviewable. It is an open ended thing that can threaten the entire centers budget."

"I think this group should endorse the proposals, then let's get together and see if we can get more money into the centers budget," Hickey said.

Cancer control, a major responsibility of some centers, has been an area of intense concern for AACI.

Terry said that his division's Board of Scientific Counselors would hear a report this week from its Cancer Control Subcommittee, chaired by Lester Breslow. The report will among other things reject the philosophy that cancer control programs cannot include research, Terry said.

Gordon Zubrod, Univ. of Miami, noted that "there are quite a number of excellent institutions where cancer control grants have been approved but not funded. We need stability. We will lose the whole program if it comes in fits and starts." Zubrod cited instances where centers have been told they cannot reapply for grants until new cancer control guidelines are available, leaving them for indefinite periods without funding.

Terry said that as those come up, they are being extended administratively. Grants "with reasonable priority scores have been funded, and I think most of the good ones have been. Priority scores for cancer control grants which will be funded will shock many of you. They will be way below what is reasonable. Stability is absolutely essential in dealing with communities."

Referring to the cancer control contracts with which some Cooperative Groups work to extend clinical research into community hospitals, Terry noted that to be eligible for control money, "the quality of care will have to be favorably and measurably changed." The Groups have looked upon the program as a means to improve the flow of patients into clinical trials; while that is an extremely important aspect of the program, the requirement that the quality of diagnosis and/or treatment be improved cannot be overlooked.

Terry credited Diane Fink, former director of the Div. of Cancer Control & Rehabilitation, with establishing the Cancer Control-Cooperative Group program. "It has been exceedingly effective" in bringing more patients into clinical research, he said. The Eastern Cooperative Oncology Group is now getting 35 percent of its patient flow "as a direct consequence of its cancer control contract," Terry said.

Guy Robbins, Memorial Sloan-Kettering, objected to what he said was inadequate review by cancer control grant site visit teams. "Someone comes in with one interest or area of expertise and then is the biggest talker about something he knows nothing about."

Terry agreed, "We have to improve the system. The Board of Scientific Counselors will have to work on it."

NCI MAY ASK FOR CUTS IN R01s, P01s IF CONGRESS APPROVES RESCISSION

The Carter Administration and Congress during the last two years agreed on the policy of maintaining the number of NIH research grants at a fixed level of about 5,000. Whever budget cuts were made, money was taken from other categories but R01s remained untouched.

Carter's last gasp rescission request which would cut $13.5 million from NCI's 1981 appropriation of $1.001 billion was no exception. The proposed reduction would be spread among eight categories, none of them R01s or P01s.

The rescission would trim nearly $1.6 million from an already tight center program budget, leaving

almost no money for increased budgets for competing renewal core grants.

NCI Director Vincent DeVita hinted this week that the protected status of R01s and P01s might be changed. Responding to a suggestion by Richard Steckel, UCLA, at the meeting of the Assn. of American Cancer Institutes that R01 and P01 grants "share in the sacrifices," DeVita agreed.

"Yes, there has to be some equity. We have yet to test the policy of maintaining a fixed number of grants. I've told Dr. (Donald) Fredrickson (NIH director) that . . . I don't believe we can maintain 5,000 grants at NIH if the rescission goes through."

If the rescission is approved by Congress, there will be no chance at all of funding core grant renewals at recommended levels, DeVita said, "although we probably can fund all of those with reasonable priority scores (but at current levels, with small or perhaps no cost of living increases)."

Other comments by DeVita at the meeting:

- "We're not getting our share of NIH budget increases (which averaged five percent, with NCI's increase from 1980 to 1981 at one-tenth of one percent (before the rescission). Others assume that since we had so much money they could squeeze us, get us closer to our fighting weight."
- The most important problem faced by NCI is the need to "close the feedback loop. . . . We don't have the mechanism for closing it." He described the problem as one in which new developments outpace their application, with the result that unnecessary overlapping awards are made, duplicative programs supported, and unnecessary competition for resources occurs. "If we don't close it, there probably will be fewer NCI dollars in the years ahead."
- Biomedical research "is in an era unmatched in opportunities. . . . It is an era of new biology." But these opportunities are arising at a time "when we don't have much new money." Determining priorities "is very difficult."
- NCI's bypass budget request for FY 1982 of $1.192 billion was based on allowing for a 12.5 percent increase for inflation plus a five percent growth factor. Some programs within the budget were listed for more than that, some less. The bypass budget for the 1983 fiscal year, which will be presented to the National Cancer Advisory Board at its spring meeting, is being developed with the same rationale, with similar projections.
- The Biological Response Modifiers Program "is alive and well." Interferon and thymosin clinical trials have started. The program is headquartered at Frederick Cancer Research Center under Robert Oldham, and intramural clinical trials are being organized there.
- The Div. of Cancer Treatment's Drug Development Program has 17 new agents awaiting clinical testing. The program probably can move only seven of those into trials this year because of budget limitations.
- The change in FDA toxicology requirements which went into effect last year at NCI's request (eliminating tests in monkeys and reducing those required in dogs while placing more reliance on tests in mice) were projected as offering the prospect of reducing costs from $180,000 per drug to about $60,000. Instead, the cost now is about $200,000 per drug for toxicology testing; under the former requirements, the cost now would be about $380,000.
- Investigators at cancer centers "probably do have a competitive edge" over those elsewhere. "That is probably the intent of core grants. But peer review is just as rigorous, and the quality of research at centers just as high or higher."
- The Cancer Control Program "is a noble concept." Implementing it has been difficult because there was no NIH precedent. "NCI had to make all the mistakes itself." One of those mistakes was to isolate cancer control in a separate division. . . . The biggest problem was exclusion of research, along with isolation of control from its major natural companion, cancer centers.
- The concept of new geographical cooperative groups has stirred excitement around the country, and it appears there will be considerably more applying for a piece of the $1.5 million earmarked for first year support of the new groups than the three or four projected. "I not only will have to face the anger of the (existing) group chairmen, and they are angry with me. But also the anger of those in the new groups who can't be funded. I'm not negative about the existing Cooperative Groups. They have done outstanding work." Those groups are being funded this year with about $36 million from DCT, plus $3.5 million from the Div. of Resources, Centers & Community Activities for the cancer control contracts to include community physicians in clinical trials. Also, NCI gives the groups about $2 million worth of drugs a year.
- The new grant supported program in surgical oncology approved by the DCT Board of Scientific Counselors "gets at the crux of the problem" of attracting surgeons into cancer research. Plans for the program are in progress; support will be available for planning grants, probably for development into program projects.

REAGAN FREEZE SLAMS DOOR ON OUTSIDE HIRING TO FILL KEY NCI VACANCIES

NCI will be particularly hard hit by President Reagan's total freeze on government hiring if Director Vincent DeVita cannot obtain exemptions for key positions he is ready to fill.

Four of NCI's five divisions are without permanent directors, and search committees have been active in developing lists of candidates for three of them. In addition, the NCI deputy director's office has been vacant for nearly two years, and DeVita—who is also continuing as NCI clinical director—desperately needs someone in that job.

Search committees have just about completed identifying and screening candidates for directors of the divisions of Extramural Activities, Cancer Cause & Prevention, and Resources, Centers & Community Activities, and for NCI deputy. DeVita said "there are some excellent people" on the lists submitted to him.

Because of the freeze, however, he can hire only those who are already working in the Dept. of Health & Human Services; he can't even bring in federal employees from other departments.

DeVita had hoped (and still does) to fill some of the vacancies with people from outside government. One NCI executive said, "Vince wants the best people available and will fight if necessary to get those from outside." He has submitted a formal request to exempt division directors and the deputy from the freeze.

The freeze as it now stands also will affect advisory committees and boards. Members are considered federal employees on the days they are meeting, and vacancies which occur probably will not be filled until the freeze is modified or lifted.

One major vacancy which will appear among NCI advisors next month is that of chairman of the President's Cancer Panel. Joshua Lederberg was appointed only last year, but the appointment was to fill the rest of Benno Schmidt's three year term. The Carter Administration dallied for two years before making the appointment. Since the Reagan Administration has exempted political appointments from the freeze, there would be no problem in filling the Panel vacancy if it wants to. A number of names have been submitted to the White House and to HHS Secretary Richard Schweiker for the position.

NCI was also hit by the freeze when it was applied for the first time to the authority (granted by the National Cancer Act) to hire up to 200 experts for as much as two years, bypassing the usual civil service route. The freeze imposed by the White House is in direct conflict with the terms of the Act and with the intent of Congress and probably is illegal, if anyone cares to challenge it.

Past hiring freezes have been notoriously ineffective in achieving any substantial reduction in federal spending. Even if the goal of a 10 percent reduction is reached, the total amount of money that it would save—an estimated $500-500 million—is peanuts in a budget approaching $700 billion. Resulting inefficiencies could quickly eat up most of that.

Total federal employment now is less than it was in 1960 despite the growth in population from 185 million to 225 million, and the substantial increase in demand for federal services. It is at the state level where public employment has mushroomed.

One NCI search committee which has not yet developed a list of candidates is that which will look for a new Div. of Cancer Treatment director. That job won't be filled until DeVita can be reasonably certain the new Administration will let him stay as institute director.

A confidential list was circulated among some HHS offices last week containing names of those in presidentially appointed positions who will not be asked to resign. NIH Director Donald Fredrickson's name was on it, but no other from NIH. That may not be as ominous as it sounds; most of those the Administration wants out have already been asked to leave. It is becoming apparent that neither Reagan nor Schweiker intends to turn scientific appointments into political ones.

NCI ADVISORY GROUP, OTHER CANCER MEETINGS FOR FEBRUARY, MARCH, FUTURE

National Cancer Advisory Board Subcommittee on Organ Site Programs—Feb. 1, NIH Bldg 31 Rm 8, 7:30 p.m., open.
National Cancer Advisory Board—Feb. 2-4, NIH Bldg 31 Rm 6, open Feb. 2, 8:30 a.m.–3 p.m. and Feb. 4, 8:30 a.m.–adjournment.

NCAB Subcommittee on Centers & Construction—Feb. 2, NIH Bldg 31 Rm 6, 5:30 p.m., open.

NCAB Subcommittee on Planning & Budget—Feb. 2, NIH Bldg 31 Rm 11A10, 7:30 p.m., open.
Advances in Gynecologic Oncology—Feb. 5, Roswell Park continuing education in oncology. Contact Gayle Bersani.
Coalition for Cancer Issues—Feb. 6, Georgetown Univ. School of Medicine Faculty Room, 9:30 a.m.
Div. of Cancer Treatment Board of Scientific Counselors—Feb. 12-13, NIH Bldg 31 Rm 10, open Feb. 12, 8:30–10:30 a.m. and 1:30 p.m.–adjournment, open Feb. 13, 8:30 a.m.–adjournment.
Clinical Cancer Investigation Review Committee Subcommittee on Budgets—Feb. 13, NIH Bldg 31 Rm 8, 8:30 a.m.
National Toxicology Program Board of Scientific Counselors Technical Review Committee—Feb. 18, NIH Bldg 31 Rm 6, 9 a.m., open. Bioassay reports will be reviewed on 11 substances: C.I. acid orange 10, 11-aminoundecanoic acid, C.I. disperse yellow 3, D and C red No. 9, C.I. solvent yellow 14, eugenol, vinylidine chloride, agar agar, guar gum, gum Arabic, gum tara.
Breast Cancer Task Force—Feb. 23-24, NIH Lister Hill Auditorium, 8:30 a.m. both days, open.
Clinical Cancer Investigation Review Committee—Feb. 23-24, NIH Bldg 31 Rm 6, open Feb. 23 8:30–11 a.m. for minisymposium on the role of pathology in Cooperative Group studies.
Clinical Cancer Education Committee—Feb. 25-26, NIH Bldg 31 Rm 4, open Feb. 25, 8:30–9:30 a.m.
15th Annual St. Jude Children's Research Hospital Clinical Symposium—Feb. 27-28, Memphis.
Research Advances in Cancer Diagnosis—Feb. 28-March 1, UCLA Jonsson Comprehensive Cancer Center.

Large Bowel Cancer Review Committee—March 2-3, M.D. Anderson Hospital, open March 2, 7:30 p.m.—8 p.m.
Molecular Interrelations of Nutrition and Cancer—March 4-6, M.D. Anderson 34th Annual Symposium on Fundamental Cancer Research. Houston Shamrock Hilton.
Texas Society of Cytology 10th Annual Meeting—March 6-7, Amfac Hotel, Dallas-Fort Worth Regional Airport.
Multimodal Treatment of Melanoma—March 7, Roswell Park continuing education in oncology.

Current Topics in Biostatistics and Epidemiology—A Memorial Honoring Jerome Cornfield—March 8-9, NIH. Scholars will review the wide variety of contributions to biomedical research made by the late Professor Cornfield, and to discuss current topics in biostatistics and epidemiology related to his areas of interest. Contact Toby Levin, Conference & Seminar Branch, Fogarty International Center, Bldg 38A Rm 612, NIH, Bethesda, Md. 20205, phone 301-496-4627.
Cancer Control Grant Review Committee—March 9-10, NIH Bldg 31 Rm 7, open March 9, 8—8:30 a.m.
19th Annual National Conference on Breast Cancer—March 9-13, Hotel Del Coronado, San Diego.
Cancer Special Programs Advisory Committee—March 12-13, NIH Bldg 31 Rm 10, open March 12, 9—10 a.m.
4th Annual Symposium on Patient Education—March 12-15, Golden Gateway Holiday Inn, San Francisco.
Childhood Cancer—Triumph Over Tragedy—March 13-14, 16th Annual San Francisco Cancer Symposium, Hyatt Regency Hotel.

Photochemical Toxicity—March 16-17, Uniformed Services Univ. of the Health Sciences, Bethesda. Sponsored by the Food & Drug Administration. Interactions of chemicals which become highly toxic in the presence of light will be examined. Also, how chemical photosensitivity manifests itself in people and animals; current testing methodology; how available tests predict human consequences of exposure to light and chemicals; how endogenous chemical photosensitizers affect individuals; and the adequacy of available tests to deal with risk of cancer from light induced chemical action. Contact Dr. Constantine Zervos, FDA (HFY-31), 5600 Fishers Ln., Rockville, Md. 20857. Phone 301-443-4490.

Third International Conference on the Adjuvant Therapy of Cancer—March 18-21, Tucson Convention Center, Arizona, sponsored by Univ. of Arizona.
Cancer Centers Support Grant Review Committee—March 19-20, NIH Bldg 31 Rm 6, open March 19, 8:30—10 a.m.
Clinical Cytopathology for Pathologists—March 22-April 3, Johns Hopkins Univ. School of Medicine postgraduate course.
Gyncologic Oncology—March 23-24, Johns Hopkins nursing seminar, Turner Auditorium, Baltimore. Focus will be on current management of the gynecologic cancer patient. Contact Course Coordinator, Johns Hopkins Univ., Turner 22, 720 Rutland Ave., Baltimore 21205, phone 301-955-5880.

FUTURE MEETINGS

New Drugs in Cancer Therapy—Oct. 15-17, Institut Jules Bordet, Brussels. Discussion will include phase 1 and 2 clinical data, including drug pharmacology, with investigational anticancer agents. Preclinical aspects in the new drug development area also will be covered with emphasis on the role of the human stem cell assay in screening of new antitumor agents. The program will include invited presentations and free communications. The latter will be selected from submitted abstracts. Abstracts must be received by Aug. 31. Contact Dr. M. Rozencweig or Dr. M. Staquet, EORTC Data Center, Institut Jules Bordet, 1 rue Heger-Bordet, B-1000, Brussels, sponsored by EORTC and NCI.

NEW PUBLICATIONS

The following publications are available free of charge from NCI's Office of Cancer Communications. They may be obtained by writing to OCC, NCI, Bethesda, Md. 20205, or by calling the toll free number, 800-638-6694.

"Coping With Cancer: A Resource for the Health Professional," edited by Barbara Blumberg, Mara Flaherty, and Jane Lewis. Discusses responses to the disease, known methods of support, and sources for additional information. Other publications produced by NCI's Coping with Cancer Program include "Eating Hints—Recipes and Tips for Better Nutrition During Cancer Treatment"; "Chemotherapy and You—A Guide to Self Help During Treatment"; "Radiation Therapy and You"; "Taking Time—Support for People with Cancer and the People Who Care About Them"; "What You Need to Know About Cancer." Other materials are available on young people with cancer and for health professionals. OCC will supply lists of these materials on request.

"Students With Cancer; A Resource for the Educator," produced by NCI in cooperation with the Washington D.C. Metropolitan Candlelighters and the Dept. of Pediatric Hematology-Oncology of the Univ. of Kansas Medical Center.

"Breast Exams—What You Should Know," edited by Joan Hartman.

"If You've Thought About Breast Cancer," by Rose Kushner. Describes in lay language symptoms, diagnostic procedures, staging, treatment alternatives, rehabilitation methods, and information sources.

Three new publications produced by the Sidney Farber Cancer Institute Regional Cancer Control Committee may be obtained from the Institute, 44 Binney St., Boston 02115, phone 617-732-3150:

"Smoking Prevention: Bright Ideas for Smoking Education Programs in Schools," compiled by Charlene Dolan.

"Hospice: A Massachusetts Perspective," compiled by Joel Abrams, Robin Driscoll, Mary Goon, and Carol Stolberg.

"Primary Breast Cancer: Recommendations for Diagnosis and Treatment." The recommendations are those of Farber's Subcommittee on Breast Cancer, chaired by Douglas Marchant.

The following are available from commercial publishers:

"Choices: Realistic Alternatives in Cancer Treatment," by Marion Morra and Eve Potts. Avon Books, 959 Eighth Ave., New York 10019, $8.95.

"Augmenting Agents in Cancer Therapy," edited by Evan Hersh, Michael Chrigos, and Michael Mastrangelo, $49; "Genes, Chromosomes, and Neoplasia," edited by Frances Arrighi, Potu Rao, and

Elton Stubblefield, $49.50; and "The Nitoquinolines (Carcinogenesis: A Comprehensive Survey)," edited by Takashi Sugimura. All available from Raven Press, 1140 Avenue of the Americas, New York 10036.

"Cloning of Human Tumor Stem Cells," edited by Sydney Salmon. Guide to the culture of tumor stem cells and the potential applications of these cultures in cancer research. Alan R. Liss Inc., 150 Fifth Ave., New York 10011. $44.

RFPs AVAILABLE

Requests for proposal described here pertain to contracts planned for award by the National Cancer Institute unless otherwise noted. Write to the Contracting Officer or Contract Specialist for copies of the RFP, citing the RFP number. Some listings will show the phone number of the Contract Specialist who will respond to questions. Listings identify the respective sections of the Research Contracts Branch which are issuing the RFPs. Address requests to the Contracting Officer or Contract Specialist named, Research Contracts Branch, National Cancer Institute, Blair Building, 8300 Colesville Rd., Silver Spring, Md. 20910. Deadline date shown for each listing is the final day for receipt of the completed proposal unless otherwise indicated.

RFP N01-CM-15735-56

Title: *Nutritional assessment of cancer patients*
Deadline: *March 26*

Detailed nutritional assessment of a cohort of patients with cancer. In particular, substantial input into the design of studies which will insure the accurate efficient evaluation of the nutritional aspects of patients with advancing malignancy is desired. This input will include specific program-directed research from a series of qualified institutions and investigators, as well as direction and approval of investigator initiated projects.

It is anticipated that a common core of assessment techniques will be employed in the evaluation of these patients, but a variety of additional techniques may be funded. Techniques of measurement which have been utilized in other fields or de novo methodologies may be considered.

The specific issues to be addressed include the study of perturbations of a variety of nutritional parameters in the patient with advancing cancer and whether these deficiencies are correctable by existing methods of nutritional intervention. The offeror should propose a limited number of categories of cancer for study. The selection of the cancer categories should be based on considerations of the frequency of weight loss as a systemic effect of cancer with respect to the length of the clinical history of the tumor.

Tumor categories which should be included are metastatic breast carcinoma and/or metastatic non-small cell carcinoma of the lung. Patients selected should not have received prior systemic therapy for metastases. A minimum of 50 previously untreated patients per year will be required.

Contract Specialist: Ann Peale
Cancer Treatment
301-427-8737

RFP N01-CM-15736-56

Title: *Calorimetry in cancer patients*
Deadline: *March 27*

Conduct detailed calorimetry studies in a cohort of patients with cancer. In particular, substantial input into the design of studies which will insure the accurate and efficient evaluation of the nutritional aspects of advancing malignancy is desired.

A variety of techniques may be funded. It is not anticipated that de novo methodologies will be used; however, techniques of measurement which have shown success in other fields may be adapted. Specific issues to be addressed include, but are not limited to: the resting caloric expenditure, the response to exercise, the response to eating, the response to protein-calorie supplementation.

The offeror should propose a limited number of categories of cancer for study. The selection of cancer categories should be based on considerations of the frequency of weight loss as a systemic effect of cancer in the absence of evidence of interference with gastrointestinal function. Also to be considered are tumor stage and the possibility of changing tumor status (such as with response to therapy), which might permit studying the patient at a time when tumor is present and at a time when the patient is free of clinically detectable tumor. A minimum of 20 patients will be entered per year for two years.

Contract Specialist: Damian Crane
Cancer Treatment
301-427-8737

NCI CONTRACT AWARDS

Title: Collection and evaluation of human tissues and cells from patients with an epidemiological profile
Contractor: Univ. of Maryland (Baltimore), $1,824,003.

The Cancer Letter _Editor Jerry D. Boyd
Published fifty times a year by The Cancer Letter, Inc., P.O. Box 2370, Reston, Virginia 22090. Also publisher of The Clinical Cancer Letter.